Letters to the Editor

CONFERENCE 1997
CALL FOR ABSTRACTS

First Australasian Conference on Hepatitis C on 16-18 March, 1997 The Hyatt Regency, Sydney CALL FOR ABSTRACTS Registration Information: Conference Secretariat

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Cathryn Murphy
Infection Control Association of NSW,
150 Albion Street,
Surry Hills NSW 2010
Dear Cathryn,

I would like to take this opportunity to thank the Association for giving me a "once-in-a-lifetime" opportunity of attending the APIC Conference in Atlanta.

The Conference was on a very large scale with 2000 delegates from all over the world, plus 1100 trades.

Atlanta in June was very pleasant and did not have the problem or conflict associated with the Olympics.

It was indeed an eye opener for me and a wonderful opportunity to partake of their experiences in the Infection Control field. I met some wonderful people, shared some lovely times and can now understand the true meaning of southern hospitality.

Once again I thank the Association for their part in this wonderful prize and for giving me the chance to learn about the latest trends in infection control practices in the States.

Yours faithfully,
Judy Fisher
9 August, 1996

Ms Dianne Dalton
Editor-in-Chief
Australian Infection Control Journal
Dear Ms Dalton,

We would like to thank Dr Rob Baird for identifying some current issues in infection control in his 'Letter to the Editor' (Vol 1, Issue 6, Sep 1996) that may be clarified.

In response to the article mentioned by Dr Gerberding, which was published in the Journal of the American Association in 1995, the following points are important.

- The article is an observation of an outbreak among patients receiving home intravenous infusion therapy, not a controlled clinical study of infection rates associated with needleless systems.
- The routine practice and adherence to good handwashing and aseptic swabbing techniques is extremely important in the healthcare environment, irrespective of a hospital or home care setting.
- There is a recommendation from the Centres of Disease Control that central venous catheters supplying TPN fluid to patients should have line and injection site changeovers every 24-48 hours.
- Baxter and the CDC have worked diligently to examine the potential for infection rates using controlled clinical studies. InterLink and the conventional IV access system provided similar results in downstream potential infections and these rates were significantly reduced by the action of effective site swabbing. A copy of controlled clinical study results is available from Baxter or Becton Dickinson on request.

InterLink has been widely available in both the USA since 1989 and Australia since 1993. There are a significant number of US studies that support the benefits of the Interlink needleless IV access system which are also available on request.

Kind regards,
Julie Toma, Business Coordinator, Safety Products,
Becton Dickinson; and
Bill Houghton, Business Manager, Hospital Products, Baxter Healthcare.

Interlink is a registered trademark of Baxter Healthcare.

Editor Australian Infection Control
150-154 Albion St,
Surry Hills NSW 2010
Dear Ms Dalton,

Can we please have a letter to the editor in your fine journal:

Closed Drainage Systems

With the growing concern of disease transmission (especially hepatitis viruses and HIV) by blood and body fluids, we were keen to improve the infection control of our angiography and interventional radiological procedures so as to reduce the risk to our nursing and medical staff.

Our previous system was for nursing personnel to draw from a 500ml bag of 0.9% Normal Saline with 1,000 units of Sodium Heparin utilising a 20ml syringe and use this for catheter, wire and tubing flushing. Any contaminated fluid was syringed into a slush bowel, and was a risk of spilling contaminating the sterile field, splashing onto personnel, and splattering onto the floor and nearby equipment.

The Merit Disposal Depot has two benefits: firstly it allows the flush solution to be drawn from a standard IV type bag via a needleless port, and secondly a valve in the same needleless port provides for the contaminated fluid to be disposed of through a closed drainage system into the waste bag attached. The waste bag has an adjustable metal clip to enable the scrubbed nurse to attach the bag to the drape on the procedure trolley. The port is fitter with the luer-lock system to prevent accidental disconnections and their potential for contamination.

In our trial of six patients we have found this to be a large quality improvement which reduces the cross infection risk, and of course produces less mess to clean. We have now arranged for this closed drainage system to be incorporated into our pre-packed Cook angiography kits.

K Hool NPC, C Martin RN
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To the Editor

We read with interest the article in the June edition on prevention strategies for neonatal Group B Streptococcal infection. To determine the extent of the problem in the ACT, from 1 January

1992 to 31 December 1994 we prospectively recorded details of:

- all neonates with group B streptococus cultured from sterile sites (in particular, blood and cerebrospinal fluid);
- infants who appeared to have a septic syndrome and GBS antigen detected in their urine, or had GBS cultured from a gastric aspirate associated with a syndrome of systemic sepsis; and all stillbirths or deaths in utero beyond 20 weeks in which the foetus or the mothers vagina had a heavy growth of GBS.

Only Woden Valley Hospital (WVH) now The Canberra Hospital (TCH) and Calvary were delivering babies during that time period, and all specimens were processed in the microbiology department at WVH. Of the 14,528 babies born, 49 were diagnosed as having systemic sepsis due to GBS (3.4/1000 births). Forty-four episodes of sepsis occurred within 48 hours of birth, four at 3-5 days and one at 22 days. Of the 49 infected neonates, 21 bacteraemia, 17 had systemic sepsis, one had meningitis, two had joint infections and one had pneumonia. There were seven deaths including four in utero.

Our data reinforces the fact that GBS infection in neonates is a common problem in Australia. Various strategies have been suggested to overcome the problem. The Morbidity and Mortality Weekly Report (MMWR) 31 May 1996 recommends two approaches for dealing with prevention of neonatal Group B Streptococcal Disease. These are:

1. Screening based approach. All pregnant women should be screened at 35-37 weeks' gestation Intrapartum chemoprophylaxis should be offered to those women identified as GBS carriers.
2. Risk factor approach. A prophylaxis strategy based on the present of intrapartum risk factors alone.

We believe the best strategy in terms of clinical outcome and cost is not to screen everyone routinely during pregnancy, but to give penicillin intravenously to women identified to be at risk during labour (ie those in premature labour [<37 weeks], those who have prolonged rupture of membranes, those with fever or those who have any clinical signs suggesting chorioamnionitis). Such intervention should decrease the rate of sepsis by 60-80%. Because sepsis appears to commence before birth it is essential that antibiotics cross the placenta to the infant and not wait till after birth. We have promoted this strategy in TCH since 1993.

References

1. Garland S M, Kelly N. Early onset neonatal group B streptococcal sepsis: economics of various prevention strategies. Med J Aust 95; 162: 413-417.
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3. Collignon P, Dreimanis D, Vaughan T, Jarvis, Group B streptococcal infection in neonates. Med J Aust 96; 164: 125-126.
4. Centres for Disease Control Morbidity and Mortality Weekly Report, Prevention of Perinatal Group B streptococcal Disease: A Public Health Perspective, May 31, 1996.

HIV/AIDS EDUCATOR:
North Western Adelaide Health Service

Karleen Thornton
Clinical Nurse Infection Control and HIV/AIDS Educator
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The role of education within any industry provides the foundation for better practice and a sound understanding of the workplace. From this perspective, the Queen Elizabeth Hospital appointed an HIV/AIDS Educator in October 1995 to enable staff to have easy access to an individual with expert knowledge on the subject. This new position covers both campuses of the North Western Adelaide Health Service and is seen as an adjunct to the Infection Control Practitioners HIV/AIDS at both the Lyell McEwin Health Service and the Queen Elizabeth Hospital. The HIV/Educator works in a dual role which also incorporates Infection Control.

At the same time the QEH created a social work role to provide a support service for patients and their families which means that there is a "packaged" service comprising Infection Control Practitioners, HIV/AIDS Educator and an HIV/AIDS Social Worker.

The role of the HIV/AIDS Educator is to provide information on HIV/AIDS issues for all staff and patients. In order to identify these issues, a questionnaire covering basic knowledge such as transmission modes, Universal Precautions, safe work practices and general knowledge on HIV/AIDS was randomly distributed to 10% of staff at both work sites. The information gleaned from the results was then translated into target topics and target groups for education sessions. The most favourable outcome thus far has been the response from individual wards and departments who have specifically requested or shown an interest in the issues identified.

Education sessions are built around a theme related to HIV/AIDS, including specific focus to relate issues back to the area that the session is directed at. Theatre staff were provided with sessions that covered the basics on HIV/AIDS and included the practice changes implemented to reduce sharps injuries and mucous membrane exposure to blood and body fluids in that setting. A Paediatric Ward received general information and also covered the presenting features of an infant with HIV.

As a time saving strategy it has been useful to combine HIV and Infection Control educators in the one session for support services such as catering and porters as the information has overlapping features.

The role of the HIV/AIDS educator is not only educational but is also to act as a resource person for all staff, patients and their families. This is achieved by providing articles and pamphlets, researching clinical questions, and providing information to individuals.

With hospital staff under enormous pressure, education in the workplace is often not a priority when compared to the pressing demands of direct patient care, but with endurance and persistence it is envisioned that many more staff will avail themselves of access to the new HIV/AIDS Educator service to benefit themselves and their patients.